and so I did not have an opportunity to try it; but I feel that it would be an advisable procedure in such cases. It might even be useful in smaller colobomata of the iris, where dazzling may be a problem.

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DOHRMANN K. PISCHEL, M. D. (490 Post Street, San Francisco). — Doctor Wilson has presented a group of very interesting cases. I believe the study of such unusual cases is very valuable, not from the standpoint of the patients perhaps (for, unfortunately, we can do little for them), but from the standpoint of the doctor who makes the report. When we encounter unusual cases in the humdrum of our routine practice, we should seize the opportunity of studying them. The work of looking up the literature, studying other men's findings, and so forth, will prove stimulating to us and keep us from getting stale in our work.

Doctor Wilson has done this for himself and has given us, together with case reports, such a good résumé of the theory as to how these coloboma occur that there is nothing more for me to say on that score. However, I feel that we can do these adult patients a good service by pointing out that what vision they have will be kept. Furthermore, the possibility of having defective offspring should be pointed out to those who have a family history of this defect. And in children, by careful refraction, by reference to sight-saving classes, by instruction in eye hygiene, we can help them to develop and keep what vision they have.

DERMATOLOGIC PEN-POINTS

By MOSES SCHOLTZ, M.D.
Los Angeles

DISCUSSION *by Harry E. Alderson, M. D., San Francisco; H. J. Templeton, M. D., Oakland; Louis F. X. Wilhelm, M. D., Los Angeles.*

1. Do not forget that athlete's foot may attack any part of the body.

2. Remember that two per cent hydrarg. ammoniate is more effective than five per cent, and five per cent is more effective than ten per cent in impetigo, because of its irritating qualities.

3. Do not fail to watch a luetic patient under specific treatment for itching or macular papular rash on the arms and body. These symptoms may be the first danger signal of the impending arsenical dermatitis.

4. Do not call any sore in the mouth Vincent's infection. It may be any of a great number of conditions, including syphilis, beginning cancer, tuberculosis, etc.

5. Also the tongue is subject to a great variety of dermatologic conditions, including persistent paresthesias and hyperesthesias.

6. Poison oak is a very much abused dermatosis. Many skin lesions developing subsequently to it are taken for recurrences or sequelae, while actually they have nothing to do with it.

7. Pruritus ani is in many cases due to mycotic infection, and is relieved by mild fungicidal applications.

8. The individual variations of skin sensitivity (or is it psychologic aberrations of the patient?) often confound the best trained clinician. The patient claims irritation from a mild ointment, such as boric or zinc ointment, and claims relief from a "patent" (much more irritating) ointment, such as cuticura or resorcinol ointment.

9. Allergy in skin diseases is the latest cloak of our ignorance, an all-embracing term with no concrete clinical significance or any help in diagnosis in the majority of cases.

10. After all is said and done, clinical experimentation with food and contact with "allergic irritants" are the only reliable means of identification, and is superior to all fancy laboratory tests.

11. Remember there is no standard treatment for any skin condition, not even for scabies and impetigo. Even in these dermatoses, drug and dosage are often to be changed to suit the requirements and peculiarities of the individual case.

12. As to dietetic advice, the patient prefers to have a positive order and the list of specific foods which he can or must eat, rather than the negative order and the list of prohibited foods.

13. Remember that all well-marginated intertrigos with circinate borders are invariably infectious in character; they may be due to pyogenic microörganisms, fungi, monilias or other skin saprophytes, and respond best to antiseptic applications.

14. Lichen-like eruption appearing in a luetic during specific treatment is most likely due to arsphenamin or bismuth. The same is true of pityriasis rosea type of eruption.

15. Granuloma annulare, ivory-like, ring-shape, hard lesion (supposedly a mild tuberculide) occurring in children, is commonly mistaken for ringworm.

16. The latest list of exploded dermatologic therapeutic pretenders with euphonious and synthetic names includes phenyl-mercuric-nitrate ointment, quinolor ointment, absorbine, jr., thiocresol, benacol, etc.

17. The youngest of dermatologic fancies—palmar epidermophytids—did not establish its clinical legitimacy in spite of all theoretical claims.

18. Do not fail to tell female acne patients to avoid facial creams, rouge, and heavy cosmetic powders, as they counteract the best treatment. Only greaseless lotions are permissible in acne.

19. Also warn acne patients under x-ray treatment to avoid sunburn of the face, as it may precipitate x-ray intolerance of the skin.

20. Remember that the tip of the nose is the most troublesome and cosmetically responsible area. It shows the slightest scarring and discoloration. Avoid or reduce to minimum electrocautery and caustic, irritating applications.

21. Do not rush to make a diagnosis of pemphigus in suddenly appearing bullous lesions on the extremities; it may be simply insect bites, particularly those of spiders.

22. A dermatologic truism which will bear any number of repetitions: the greatest majority of therapeutic failures in skin diseases is due to overtreatment, the rest to faulty diagnosis.

23. Remember that ultra-violet light is not a panacea in skin diseases. In fact, in some dermatoses it is distinctly contraindicated and dangerous; such are cases of potential malignancy and lupus erythematosus.

24. The therapeutic skill of a clinician treating skin diseases with x-ray should be measured not

by maximum of x-ray he can give without taking a chance on the acute or chronic x-ray burn, but by the minimum of x-ray he is able to obtain clinical results with.

25. Three best therapeutic tries in the treatment of seed warts: x-ray or radium, electrodesiccation, and bismuth intramuscular injections.

26. The lips that show sensitivity to sunlight and have a tendency to dry scaling, should be watched for potential development of epitheliomatosis.

27. The best treatment for buccal leukoplakia is electrodesiccation judiciously applied and the preventive regimen, with a particular emphasis on smoking.

28. Discoid types of lupus erythematosus is not diagnosed as often as should be. It is often confused with psoriasis or plain eczema. Remember the clinical earmarks—tightly adherent scales, patular follicular ducts, and superficial atrophy.

29. The humble and yet high-hatted scabies often eludes diagnostic acumen of the general practitioner, particularly in mild and incipient cases.

30. Intractable and resistant (to mercury ammoniate ointment) impetiginous lesions often turn out to be unrecognized monilia infection. They will respond to diluted iodin solution or potassium permanganate 1-1000 to 1-2000.

31. The most effective application in trichophytic infection of the scalp in children is two to four per cent iodin crystals in goose grease and painting twice a week with four per cent solution of chrysarobin in chloroform. Weekly shaving of the scalp and daily washing is absolutely essential.

32. In treating mycotic lesions on the trunk, never fail to examine the interdigital spaces of the toes—often the primary focus of infection.

33. In localized epidermophytosis infection of the feet, axillae and groins it is important to control commonly associated localized hyperidrosis with x-ray radiation.

34. Young, particularly irritable and inflamed keloids respond readily to x-ray and radium applications, but the old hard-set keloids call for plastic surgery.

35. To name offhand two most useful drugs for internal administration in skin diseases, I shall mention calcium gluconate and sodium thiosulphate.

36. Rule out five most common causes of systemic pruritus, diabetic, leukemic, nephritic, icteric and senile, before labeling it neurotic.

37. The most effective treatment of subungual warts is three to four hours' application of unfiltered radium plaque.

38. Do not use nitric acid or silver nitrate or copper pencil for cauterization purposes. The first is too violent and leaves ugly scars, the latter are too mild and may stimulate latent malignancy.

39. Do not use phenol as antipruritic in the acute inflammatory or weepy dermatoses. Mild astringent and coating applications are more effective and harmless.

40. Do not accept the claims of commercial literature that blistering or erythema doses of ultra-violet light are necessary to cure most of the skin diseases. Just the opposite is true. Only few chronic sluggish dermatoses react well to tensive doses. The overwhelming majority of dermatoses require small fractional doses.

41. Do not use arsenic in acute dermatoses. In chronic, increase the dosage very slowly and, preferably, do not exceed five to seven drops as a maximum. Sustained use of medium doses gives better dermatologic effects and much safer. Do not allow your patient to refill his Fowler's solution or Asiatic pills without your knowledge. Remember that arsenical pigmentation and keratoses, with subsequent epitheliomatous degeneration, is a very late and insidious complication.

42. Give a chance to an old syphilitic to die from old age rather than from arsenical or mercurial poisoning.

43. One of the most spectacular and characteristic drug eruptions is that caused by phenolphthalein, presenting violaceous or bluish black sharply circumscribed lesions, in severe cases associated with blebs and bullae.

44. Do not mistake insect bites so often observed in young children, appearing as large inflammatory papules, for systemic hives or food rash. The presence of stilletto, a small central opening, localization on exposed surfaces and peculiar triangular grouping, identifies the true nature of the condition.

45. In young individuals with malnutrition and low systemic resistance, pyodermic lesions of follicular pustular or ecthymatous type may last for months, in fact years. They often pass for tuberculids and clear up under intensive tonic regimen.

46. Bromid eruption often assumes fungoid type, in which case it closely simulates tertiary, gummatous syphilids or blastomycosis. A carefully taken history will give clue to diagnosis. One should remember a peculiar capacity of bromids for a cumulative action and reabsorption from tissues into circulation, which explains the casual outcropping of new lesions after the discontinuance of the drug.

47. One of the most constant clinical partnerships is the association of seborrhea and psoriasis of the scalp. In these cases cleaning off yellowish heavy diffuse seborrhoic crusts, one finds dry infiltrated well-defined patches, which reveal on grattage, typical psoriatic papillary hemorrhages.

48. Do not mistake gyrate and crescent-like lesions of erythema multiforme for mycotic (ringworm). The lesions of erythema multiforme are smooth to touch and deep, being intra- or subcutaneous, usually deep red or violaceous in color. Mycotic lesions are either scaly or vesicular, rough to touch, and are superficial, light pink or pale in color.

49. A common source of diagnostic dermatologic errors is a failure to remember that original clinical picture of dermatosis may be modified and disguised by secondary eczematization or infection due to neglect or overtreatment. In these cases the secondary condition is to be treated first, after which the diagnosis of the primary condition is rendered much easier.

50. In the absence of definite etiology, local treatment is guided and determined by the gross clinical pathology and appearance of the lesions. In the presence of acute inflammatory process, apply cooling and protective ointments. In chronic, infiltrating lesions, use absorptive and stimulating applications, like tar. In pyogenic or mycotic lesions antiseptics and fungicidal, keratotic lesions, call for keratolytic and granulomata for absorptives, particularly iodin.

1930 Wilshire Boulevard.

DISCUSSION

HARRY E. ALDERSON, M. D. (490 Post Street, San Francisco).—These practical notes by Doctor Scholtz are well worth careful consideration by every practitioner. Every paragraph deserves discussion, and it is recommended that the entire article be read and re-read many times. I wish, however, to emphasize a few of the points and shall leave the rest for others to discuss.

The comments about the abuse of ammoniated mercury, which is commonly dispensed in too great strength, are most timely. Unfortunately, full strength ammoniated mercury ointment is frequently sold by druggists because the drug is popular with the laity.

Volumes could be written about overtreatment in general. Were it not for this common mistake, we specialists would have less to do. Often simply discontinuing the treatment and using very mild applications result in cure. Many times we see industrial dermatoses aggravated by honest but misdirected treatment, thus prolonging disability.

It is remarkable how many cases of scabies and other dermatoses are mistaken for poison oak dermatitis. Failure to respond to poison oak extract injections, and other accepted treatment, gives rise to unjustified criticism of the methods.

In discussing pruritus ani, one must remember that most cases are due to, or aggravated by conditions acting "reflexly," and that the finding of fungi in scrapings does not mean necessarily that they are primary or even important etiologic factors. Many attacks are brought on by rectal pathology with secretions originating therein.

Failure to recognize the fact that local treatment of various dermatologic conditions has to be modified to meet changes, is responsible often for disappointments.

I cannot agree with the unfavorable comment about "quinalor," for I have often found that oxyquinolin sulphate and benzoyl peroxid, properly compounded, are strikingly useful in coccogenous sycosis.

The various warnings about Röntgen therapy and ultra-violet treatment are well justified.

As for scabies, we frequently see atypical cases, and many that are masked by previous home treatment. Then there are those cases due to exposure to infested cats.

I thoroughly agree with the remarks about the efficiency of iodin crystals in goose grease for trichophytic infection of the scalp. For many years I have depended upon this preparation in these cases.

It is true that various calcium preparations seem to be useful, but I am still very skeptical about the efficacy of sodium thiosulphate, in spite of many favorable reports.

The warning about continuing arsenic administration over a long period is most timely.

The admonition to let an aged syphilitic die of old age rather than from arsenical or mercurial poisoning is one that should be printed in large type. Many an old syphilitic is "all right until the doctor sees him."

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H. J. TEMPLETON, M. D. (3115 Webster Street, Oakland).—Doctor Scholtz has succinctly given us very valuable "tips" which can be put to everyday, practical use. I shall discuss his paper by adding a few observations of my own:

Scabies.—Just as important as the treatment of the patient's skin is the disinfection of his clothing and bedding, and the treatment of any of his intimate associates who, untreated, would possibly reinfect him.

Impetigo.—Do not forget to have the patient sterilize his towels, pillow cases, and washcloths. Men should also sterilize their shaving equipment, and women should discard their contaminated powder-puffs, compacts, and creams. Else they may be reinfected.

Epidermophytosis of the Feet.—Treat the skin, of course, but also sterilize the shoes and socks. Cotton socks are preferable because, in washing them, laundries heat them past the thermal death point of the fungus. Sterilization of shoes can be attempted by placing them for twenty-four hours in a paper bag with a teaspoonful of formaldehyd on blotting paper.

Syphilis.—Success in the management of syphilis depends upon long-continued treatment. In order that this may be financially possible for the average patient, our fees should be as reasonable as we can make them. The patient is more apt to continue treatment over the necessary two- or three-year period if he has been given a minimum rate by the year or by the month.

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LOUIS F. X. WILHELM, M.D. (1401 South Hope Street, Los Angeles).—The author, in fifty terse sentences, has given us some interesting impressions of his daily experience in dermatology. While there is room for discussion in some of these statements, according to individual opinion, in the main we are in agreement. The experienced dermatologist can easily add a few observations of this character every week of his practice. We are constantly confronted with situations which we wish might have been prevented. The overtreatment of scabies and impetigo, the continued use of arsenic after definite signs of intolerance, and the further use of roentgenotherapy, despite the beginning of telangiectasis, are deplorable examples.

During the past week I saw two patients who manifested late sequellae of roentgenotherapy; both patients were treated by roentgenologists after definite signs of marked telangiectasia were clearly evident in the skin. Each patient had developed definite induration with beginning fissuring and ulceration, unquestionable signs of a pre-epitheliomatous change. One patient had been treated intermittently over a period of fifteen years, the other over a period of seven years. The one patient presented a recurrent pruritus ani, the other, a pruritic patch, probably a neurodermite of the left groin. I cannot conceive of a well-trained dermatologist countenancing the further use of roentgen-ray therapy after the appearance of such gross skin changes as telangiectasis.

Allow me, once more, to emphasize the necessity of a correct diagnosis, and the desirability of adequate knowledge of the possible harmful reactions and late sequellae of a given type of treatment before instituting therapy in a given case.

Adequate training and long experience in a given specialty, and the liberal use of consultation whenever one is in doubt, should tend to prevent many otherwise unfortunate situations. Experience develops judgment; merely reading the penpoints of an experienced dermatologist cannot make a dermatologist out of the general practitioner.

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DOCTOR SCHOLTZ (Closing).—In closing I wish to thank the discussers who deemed it worthy of debating "Dermatologic Penpoints," which were conceived rather as casual memoranda for a busy practitioner, who has no time or patience to read dermatologic manuals and so separate the wheat from the chaff.

The penpoints are based entirely on individual experience and personal interpretation of dermatologic clinical phenomena. They are not offered for dogmatic acceptance by the practitioner, but merely for practical guidance and help.